CITY OF NEW ORLEANS
ONE STOP
PERMITS & LICENSES

Business License

Date _____

Tracking Number _____

PEDICAB MEDICAL FORM — SUPPLEMENT A

IMPORTANT: This form must be completed by a licensed medical physician to determine if an applicant is physically fit to operate a pedicab.

APPLICANT INFORMATION

Applicant Name _____ Contact Number _____

Gender: Male ○ Female ○ Date of Birth _____

Pedicab Company Name _____

PHYSICIAN INFORMATION

Physician's Name _____ Contact Number _____

Physican Address _____

MEDICAL HISTORY (to be completed by the applicant)

Yes ○ No ○ Have you had a medical problem or injury since your last evaluation?
Yes ○ No ○ Have you ever been restricted from physical activity?
Yes ○ No ○ Have you ever passed out or felt dizzy during or after physical exertion?
Yes ○ No ○ Have you ever had a seizure?
Yes ○ No ○ Have you ever had problems with vision?
Yes ○ No ○ Have you ever had problems with hearing?

Please explain all yes answers:

ACKNOWLEDGMENTS

I affirm that the information given on this form is true and correct.

Applicant Signature _____ Date _____

I certify that _____ is in the physical condition to operate a pedicab.

Physician Signature _____

PHYSICAL (to be completed by the physician)

Height _____		Weight _____	
Eyes:	Right 20/	Left 20/	Corrected? Yes ○ No ○
System	**Normal**	**Abnormal**	**Comments**
Heart			
Lungs			
Hearing			
Neck			
Back			
Knees			
Ankles			
Feet			
Clearance:	○ Clearance:	○ Cleared after further evaluation/treatment	○ Not Cleared
If not cleared, please state reason: _____			
Recommendations: _____			